OKLAHOMA EAR CLINIC HEARING & BALANCE CENTER

A Division of Ear, Nose, Throat Physicians of Oklahoma

Financial Policy

Read ALL Information and Sign/ Date at The Bottom

Thank you for choosing us as your health care provider. The Physicians and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

All co-pays and co-insurance are due before you see the doctor.

All deductibles are due at the time of service.

We accept cash, checks, Visa, Mastercard, and Discover.

Regarding Insurance:
The balance on your account is still your responsibility whether or not your insurance company pays or not. We cannot bill your insurance company unless you give us your updated insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance information has changed. Be sure to give us the updated information. If your insurance company has not paid your account in full within 90 days from the date of service, the balance will automatically be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided by the Physician, Physician's assistant, audiologist, or other licensed professionals may not be covered by your insurance. It is your responsibility to know what your insurance will and will not cover. It is also your responsibility to get an Authorization, if you have an HMO insurance company, from your primary care physician before your appointment. If we do not have an authorization, the balance will become your responsibility.

Due to recent problems with coverage, you must inform us if your insurance or your PCP (primary care physician) changes. If you fail to notify us about any changes, you will be responsible for all accrued charges.

I, _____ , have read the above information and agree with the
(Print you name here)
terms of the Financial Policy.

Signature:_____Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

This acknowledges that I have received the Notice of Privacy Practices from my provider and/ or his Office staff.

Signature:_____Date:_____

10958 North May Avenue
Oklahoma City, Oklahoma 73120

INSURANCE POLICY

As of November 1, 2015, all patients are responsible for ensuring that our office is notified of all insurance updates/changes. Failure to do so will result in the patient becoming responsible for any and all unpaid claims. If you/your spouse have a new or changed insurance policy, it is your responsibility to notify our office immediately of these changes so we may update your information and the correct insurance may be billed.

Medicaid is always secondary to other medical insurance. If any new insurance is added by you/your spouse, it is very important to notify our office immediately, so we may update your information and bill the correct insurance to avoid unpaid claims.

I acknowledge and understand all the above information. My signature indicates that I have read the above information. I will be responsible for any balance due secondary to failure of notification of correct insurance information.

Signature: _____ Date: _____

Ear, Nose, Throat Physicians of Oklahoma

Patient Information

Patient' Legal Name:_____ SSN:_____

Sex: M F Race:_____ Age:_____ DOB: _____ Marital Status: S M D W

Patient Address_____ City_____ State _____ Zip Code_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referring Physician _____ Phone:_____

Patient Employer:_____ Phone:_____

Spouse Name: _____ SSN: _____ DOB: _____

Spouse Work: _____ Work Number: _____

Emergency Contact (outside of home): _____

Relationship to Patient: _____ Home/Work Number: _____

Primary Insurance: _____ Policy Holder Name: _____

SSN: _____ Insured DOB: _____

Secondary Insurance: _____ Policy Holder Name: _____

SSN: _____ Insured DOB: _____

FILL OUT ALL SPACES IF THE PATIENT IS UNDER THE AGE OF 21

Mother's Name: _____ SSN:_____

DOB: _____ Employer: _____ Phone Number: _____

Father's Name: _____ SSN:_____

DOB: _____ Employer: _____ Phone Number: _____

Authorization for services/ Please read the following and sign at the bottom of this form:

I hereby authorize payments directly to the physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information I provided herein is true and correct to the best of my knowledge.

Signature:_____ Date: _____

10958 North May Avenue
Oklahoma City, Oklahoma 73120
Ph #: 405-607-8222 Fax #: 866-322-0876

Oklahoma Ear Clinic- Hearing & Balance Center
Division of Ear, Nose Throat Physicians of Oklahoma
E. Nicholas B. Digges, M.D.

Primary/Referring Doctor: _____

Circle All Applicable
Constitutional: fever—chills--weight loss--malaise/fatigue
HENT: tinnitus--hearing loss—congestion--sore throat--neck pain
Eyes: blurred vision--double vision--photophobia--pain--discharge--redness
Respiratory: cough--hemoptysis—sputum production--shortness of breath--wheezing
Cardiovascular: chest pain--palpitations--leg swelling
Gastrointestinal: heart burn--reflux--nausea--vomiting--abdominal pain--diarrhea--constipation--blood in stool--melena
Genitourinary: dysuria--urgency--frequency--hematuria--flank pain
Musculoskeletal: myalgia--back pain--joint pain--falls
Skin: rash--itching--new/change in growths--non-healing areas
Neurologic: dizziness--tingling--tremors--sensory changes--focal weakness--seizures--loss of consciousness--weakness--headaches
Endo/Heme/Allergies: inappropriately cold/hot--bleeding--bruising, --pale--environmental allergies (nose--eyes--skin--lungs--GI)
Psychiatric/Behavioral: depression--nervous/anxious--insomnia--suicidal--hallucinations--memory loss--substance abuse/dependency

Prior Surgeries: _____

_____

Medical Conditions: _____

_____

Medications: _____

Over-the-Counter Medications: _____

Allergies: _____

Family Medical Problems: _____

Abnormal personal/ family anesthetic reaction: _____

Tobacco: Yes—No Alcohol: Yes—No Illicit drugs: Yes—No Pregnant: Yes—No

Contact Lenses: Yes—No Blood transfusion to save life: Yes—No

Patient Name: _____ Patient Signature:_____

Date: _____

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E. Nicholas B. Digges, MD

RELEASE OF MEDICAL INFORMATION RECORDS

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by Scooter Digges and Associates, PC to the above-named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes.

The information you authorize for release may indicate the presence of a communicable or venereal disease which may include, but are not limited to, hepatitis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statue 63 OS 1-502.2.

I also authorize you to accept a photo copy of this release and it shall have the same force and effect as if it were the original. I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature: _____ Date: _____

Medicare Patients Only

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature: _____ Date: _____

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